ALLERGY & IMMUNOLOGY INFUSION ORDER FORM

P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Infusion Orders		Refills
☐ Persistent Asthma (ICD-10 Code:_____) ☐ Chronic Idiopathic Urticaria (ICD-10 Code:_____) ☐ Nasal Polyps (ICD-10: _____)	☐ **Xolair** 75mg Sub-Q ☐ **Xolair** 150mg Sub-Q ☐ **Xolair** 225mg Sub-Q ☐ **Xolair** 300mg Sub-Q ☐ **Xolair** 375mg Sub-Q ☐ **Xolair** 450mg Sub-Q ☐ **Xolair** 525mg Sub-Q ☐ **Xolair** 600mg Sub-Q	**Xolair frequency:** ☐ Every 2 weeks ☐ Every 4 weeks **Patient must have Epi-Pen prescription for Xolair order.**	☐ _____ ☐ X 1 year
☐ Severe Asthma with Eosinophilic phenotype. (ICD-10:_____) ☐ Severe Granulomatosis with Polyangiitis. (ICD-10 Code:_____)	☐ **Cinqair** 3mg/kg IV every 4 weeks ☐ **Fasenra** initial dose: 30mg Sub-Q every 4 weeks for the first 3 doses followed by 30mg Sub-Q every 8 weeks thereafter ☐ **Fasenra** continuing therapy: 30mg Sub-Q every 8 weeks ☐ **Nucala** 100mg Sub-Q every 4 weeks ☐ **Nucala** 300mg Sub-Q every 4 weeks ☐ **Tezspire** 210mg Sub-Q every 4 weeks		☐ _____ ☐ X 1 year
☐ Common Variable Immunodeficiency (ICD-10: _____) ☐ Other: _____ (ICD-10 Code:_____)	Immunoglobulin: ☐ **IV** ☐ **Sub-Q** _____ mg/kg **OR** _____ gm/kg x _____ day(s) **OR** divided over _____ day(s) Frequency: Every _____ weeks **OR** _____ Brand (Active Infusions to choose if not indicated): _____ Additional Ig orders: _____		☐ _____ ☐ X 1 year

Premedication Orders:

Tylenol: ☐ 1000mg PO ☐ 500mg PO

Antihistamine: ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Other: _____

Additional premedication: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other: _____

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

ACTIVE infusions

COMPREHENSIVE SUPPORT FOR ALLERGY / IMMUNOLOGY THERAPY

P: 240-200-4464 F: 240-892-3005

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete previous page)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's mediation list
- ☐ Supporting clinical notes (H&P) to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Please indicate any tried and failed therapies (if applicable):
    - ☐ Corticosteroids: _____
    - ☐ Long-acting beta 2 agonist: _____
    - ☐ Long-acting muscarinic antagonist: _____
    - ☐ Immunosuppressants (EGPA): _____
  - ☐ **Asthma:** Does the patient have a history of two or more exacerbations requiring a course of oral or systemic corticosteroids, hospitalization or emergency room visit within a 12-month period? ☐ Yes ☐ No
  - ☐ **Asthma:** Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120? ☐ Yes ☐ No
  - ☐ **Primary Immunodeficiency:** Documentation of recurrent bacterial infections, history or failure to respond to antibiotics, documentation of pre and post pneumococcal vaccine titers
- ☐ Include labs and/or test results to support diagnosis **(attach results)**
  - ☐ Does patient have a baseline peripheral blood eosinophil level of ≥ 150 cells/mcL within the past 6 weeks *(asthma & EGPA)* or ≥ 1000 cells/mcL within 4 weeks *(HES)*? ☐ Yes ☐ No
  - ☐ FEV1 score (if applicable):_____
  - ☐ Serum IgE level – ***for asthma & nasal polyps Xolair***
  - ☐ Skin/RAST test – ***for asthma Xolair***
  - ☐ Serum immunoglobulins ***– for Immunoglobulin therapy***
  - ☐ Serum creatinine – ***for Immunoglobulin therapy***
  - ☐ CBC w/ differential – ***for Fasenra, Nucala, Cinqair***
- ☐ **Xolair – Patient has EpiPen prescribed**
- ☐ Other medical necessity: _____

Please fax all information to 240-892-3005 or email to info@activeinfusions.com for assistance

ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

☐ Phone Call ☐ Text Message ☐ Email ☐ No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder? ☐ Yes ☐ No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION